CC 96-45

NATIONAL RURAL HEALTH ASSOCIATION

April 28, 1997

Commissioner Rachelle Chong
Federal Communications Commission
1919 M St. NW
Washington D.C. 20554

Dear Commissioner Chong:

We attempted to set up a meeting with you to discuss specific provisions of the Universal Service Provision of the Telecommunications Act of 1996 but were unsuccessful. In absence of a meeting, we are dropping off materials communicating the position of the National Rural Health Association (NRHA) on this important issue for your review.

Please find attached the original comment letter sent to the Federal Communications Commission (FCC) last December on universal service and our white paper on telemedicine issues.

The members of our association believe it is imperative that a distance-neutral rate structure is adopted for all rural telemedicine services. Providing rural patients with access to the same telemedicine services as urban patients by eliminating the distance element in telecommunications rates is vital in order to provide a level playing field. By not doing this, rural residents would be denied access to health care services and essentially penalized for choosing to live in non-metropolitan areas of this country.

In addition, toll-free access to the internet for all licensed providers in rural areas is crucial in order to allow access to the same information and resources as our urban and suburban counterparts. To not have this would again, put rural patients at a significant disadvantage.

If you have any questions about our position or the potential ramifications this issue has on rural health care providers and residents, please do not hesitate to contact me. Thank you for your consideration.

Sincerely,

Jennifer L. Rapp
Government Affairs Director

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NATIONAL RURAL HEALTH ASSOCIATION

December 18, 1996

Office of the Secretary
Federal Communications Commission
1919 M St., NW, Suite 222
Washington D.C. 20554

To Whom It May Concern:

On behalf of the National Rural Health Association (NRHA), I am writing to comment on specific provisions of the Proposed Rule on the Implementation of Infrastructure Sharing Provisions In the Telecommunications Act of 1996.

The NRHA has a long history in the area of telemedicine issues. Because our membership includes rural health providers, administrators, educators and researchers, our interest and expertise in the field of telemedicine outs across traditional boundaries. We strongly support telemedicine as a means to both increase rural access to quality health care and decrease overall health care costs. Unfortunately, the long distance inherent in rural telemedicine have generally resulted in extremely high telecommunications rates that inhibit the development and use of telemedicine's potential. It was for that reasons that Congress included rural health care providers under the universal service provisions to give rural patients access to the same telemedicine services as urban patients by eliminating the distance element in telecommunications rates. We strongly urge the Commission to adopt a distance-neutral rate structure for rural telemedicine services. In addition to this point, we recommend the following with regard to scope of services:

- At the minimum, universal internes access (local dial tone) should be available to all licensed providers;
- Broadband access should be available also, if not to all licensed providers, to an aggregate entity to which licensed providers have access.
- Specific services needed would include; communication among partners in networks, including electronic transmission of patient data; support for diagnosis, including transmission of images; the development of a treatment plan, including direct consultation with image present at both ends; patient-physician counseling for routine follow up visits and behavioral counseling which would require real-time interactive televideo.

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Executive Vice President

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Regarding the definition of small rural health care providers:

- The current definition which targets hospital revenue should not be the benchmark, geographic location and populations served should be the determinant;

- The term "provider" should be defined in the broadest way possible under law. Our suggestion is to use "licensed practitioner" as the criterion;

- Consideration should not be limited to hospitals but should include rural community colleges, medical schools with rural programs, health centers, local health departments or agencies, and rural health clinics.

Regarding criteria for determining rural areas, the size of the town and remoteness (frontier areas) should be given special consideration.

The NRHA feels strongly that the regulatory approach taken should not disadvantage private practice. Geographic location and populations served should be the determining factors, not whether the entity is not-for-profit, for profit, big or small. All programs/facilities located in geographically remote areas serving those who would otherwise not have access to care should be assisted under the universal service provision.

Finally, we believe that the FCC should create a flexible implementation program in concert with Congressional intent, one which responds quickly to the communication needs of rural communities but which revisits the issue of provider eligibility, eligible services, and infrastructure development on a regular basis, to ensure that both access and cost concerns are fairly balanced.

The NRHA appreciates the opportunity to share our comments with you on this important proposed rule. If we can be of further assistance, please do not hesitate to contact Jennifer Rapp in our Washington D.C. office at (202) 232-6200.

Sincerely,

Keith J. Mueller, Ph.D.
President

NATIONAL RURAL HEALTH ASSOCIATION

THE ROLE OF TELEMEDICINE IN RURAL HEALTH CARE

An Issue Paper Prepared by the National Rural Health Association—November 1996

This issue paper presents the National Rural Health Association (NRHA) position regarding telemedicine. It does this by defining telemedicine, briefly examining its history, exploring current applications relevant to rural communities, and then suggesting policy positions at both the national and state levels that will encourage the best use of this technology to support rural practitioners and patients.

DEFINING TELEMEDICINE

Telemedicine refers to the use of electronic communication technologies to provide clinical care. This ranges from using the fax or telephone to share information through the transmission and evaluation of still images, such as radiographs or pictures of wounds, to full interactive video conferences. The term "telehealth" is sometimes used to refer to a broader group of health-related activities. Telehealth is defined as the use of these technologies to support health profession education, community health education and continuing education for health professionals in addition to clinical applications. The focus of this issue paper, however, is on the provision of clinical care and/or the provision of patient-specific consultative support from one clinician to another using electronic communications technologies.

THE HISTORY OF TELEMEDICINE

The idea that doctors might treat patients without being in the same room with them is not new. Likewise, doctor-to-doctor consultation does not require physical proximity. Stretching the definition of "treatment," Dr. Sigmund Freud's letters to his

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patients might be examples of treatment at a distance. Since the dawn of the information age to the present, doctors have been giving patients and each other advice by telephone. At a more technically sophisticated level, the astronauts from the earliest Apollo missions in the 1960s have had their bodily functions electronically monitored by NASA physicians.

In the early 1970s, as satellite transmission became more available, a number of pioneers in telemedicine began putting together systems to link physicians with often very remote clinics. One such effort supported Indian Health Service practitioners in Arizona and another reached the wilds of Alaska. In many ways, these programs did essentially what telemedicine advocates are trying now to do again. They brought specialty consultation and treatment to persons who would not otherwise have access to such care. There is, however, an important difference between then and now—that difference is cost.

These early efforts foundered in part because they were immensely expensive to operate. Without generous grant support, it was not economically feasible to use satellite transmission to support rural health care beyond the "demonstration project" phase, and telemedicine efforts all but vanished. In the intervening years, however, a number of events have occurred that have lead to renewed interest in the area, and reductions in communication costs leads the list.

First, satellite technology has dropped in cost sufficiently to allow its use by at least some health care delivery systems. However, a second development is more important by far. The creation and increasingly wide dissemination of broad band telephone networks has made telemedicine an economically feasible undertaking for individuals and institutions interested in trying it. It also has created a market driven incentive for communications companies to be helpful in such efforts. In a similar way, the hardware and software that are used in these applications are growing less expensive. Most of the telemedicine systems currently in place or in development use this ground-based technology.

Several other factors have contributed to the rebirth of interest in telemedicine. The widespread availability of personal computers is a factor of great importance—more and more people, including doctors, are less and less put off by computers, and

computers lie at the heart of these systems. The use of teleconferencing by business has spurred development of the technology that is now being explored for clinical applications. Finally, specialists continue to be located largely in urban cities, while many patients reside in rural areas of the country. Getting them together is a recalcitrant problem that this technology may help to solve.

TODAY'S TELEMEDICINE

Currently, there are telemedicine projects using video conference technology in various stages of development or implementation in at least 33 states. While all of these projects include clinical care as a part of the mission, other activities, such as continuing education, absorb much of the network time. While a few projects have been developed entirely with institutional funds, in most instances these efforts are heavily supported by federal grants from agencies such as the Office of Rural Health Policy (ORHP) in the Department of Health and Human Services (DHHS). State funds and contracts for service support many projects as well. An explicit expectation of federal funding, and an expectation implicit in most other funding, is self-sufficiency at the end of the grant support. This hope for self-sufficiency is generally based on the assumption that clinical service provided over these networks will ultimately be reimbursed by third-party payers, including Medicare and Medicaid.

At this time, however, telemedical services are generally not reimbursed. Exceptions to this rule are still image technologies such as telepathology and teleradiology, for which it can be argued that the service being performed at a distance is identical to that which could be performed were the patient and physician proximal. For such services, Medicare is currently a payer as are some commercial vendors and Medicaid in some states. Such services may be of value to rural communities, but they account for a small fraction of the potential quantity of clinical transactions that telemedicine might provide. It is reimbursement for this broader range of services that is an unresolved and vital issue to the future of telemedicine.

A number of demonstration projects involving reimbursement for telemedical services through Medicaid and Medicare are currently underway. Looking first at

Medicaid: "The Health Care Financing Administration (HCFA) has not formally defined telemedicine, and Medicaid law does not recognize telemedicine as a distinct service. Still, Medicaid reimbursement for services furnished through telemedicine applications is available as an optional cost-effective alternative to direct consultations or examinations, or as an element of many other Medicaid covered services" (HCFA Policy Summary, Sept. 13, 1996). Currently, at least nine states use Medicaid funds to pay for telemedicine services. In doing so, they must meet the usual Medicaid requirements for efficiency, economy and quality of care. Modified Current Procedural Terminology (CPT) codes have been developed in some states to cover these services while others have developed new codes to identify telemedical services. In general, states have wide latitude in defining telemedical services that can be reimbursed.

With regard to Medicare: "Vice President Al Gore and Department of Health and Human Services Secretary Donna Shalala on October 7 announced two initiatives that will further expand the federal government's support of telemedicine. One initiative directs HCFA to reimburse the five Medicare demonstration projects that were selected in 1993 and 1994" (Association of American Medical Colleges [AAMC] Washington Highlights, 7, 36, Oct. 10, 1996). The recently enacted bill on portability, sponsored by Sens. Edward Kennedy, D-Mass., and Nancy Kassenbaum, R-Kan., contains language requiring the HCFA to complete work on the creation of guidelines for reimbursement for telemedicine. A bill filed at the close of the 104th Congress by Sen. Kent Conrad, D-N.D., also supports Medicare reimbursement for telemedicine.

The debate concerning reimbursement for telemedicine turns on the joint issues of clinical efficacy and cost effectiveness. The current literature on these two subjects is woefully lacking, and a recent Institute of Medicine (IOM) report lays out an agenda for correcting this. The report was commissioned by the National Library of Medicine (NLM) and lays out an agenda for studies to evaluate the efficacy of telemedicine in a variety of clinical contexts and geographic locations. Both video-interactive and lower cost, still-image methodologies are to be focused on in these studies. The NLM will invest $42 million over the next few years to fund 19 demonstration projects designed to contribute to meeting the objectives of the IOM report.

SUMMARY

There currently is an ongoing process of experimentation, evaluation and implementation of telemedicine applications in many urban and rural locations around the country, and the advocates for these technologies are numerous and enthusiastic. However, a patchwork of funding mechanisms is to be found, and reimbursement for such services is currently the exception rather than the rule. The efficacy of these methods has not been fully demonstrated. Likewise, the potential effects of their widespread implementation on the health care delivery system are unknown.

NRHA POLICY POSITIONS

Looking at the current activities in telemedicine as a whole, the NRHA believes that these technologies hold promise for improving access to health care services for rural patients. Accordingly, the association favors initiatives designed to systematically evaluate these methods to encourage the development throughout the country of the communications infrastructure that supports them and to encourage implementation of telemedicine programs that enhance rural health care. Specific NRHA policy positions are as follows.

1. The NRHA supports funding for telemedicine evaluation studies that build on the framework outlined in the IOM report, *Telemedicine: A Guide to Assessing Telemedicine in Health Care.* The particular needs of rural providers should animate a significant percentage of these studies.

2. The NRHA supports Medicare, Medicaid and commercial vendor reimbursement for telemedicine services for which there are reasonable demonstrations of efficacy and cost effectiveness. The standards of efficacy and cost effectiveness to which telemedical services are held should not, the association believes, differ materially from those of other clinical services.

3. The NRHA strongly supports regulatory language that requires equal and cost-competitive access to communications infrastructure for rural communities. Such infrastructure, while essential to the practice of telemedicine, also is a critical element in rural economic development in general. Equitable access to such infrastructure should be a national priority.

4. The NRHA believes that an appropriate balance between protection of local health infrastructure and increased access to regional or national provider resources should be a goal in the development of telemedical systems reaching rural communities. Accordingly, the association supports careful study of the implications of current state licensing laws on telemedical practice across state lines and urges the Agency for Health Care Policy Research (AHCPR), the ORHP, the HCFA or other appropriate federal agency to commission such a study.

5. The NRHA supports giving a preference or priority in grant reviews to applicants that are part of telemedicine systems and/or networks. ■

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